REFLECTIONS OF CHILD HEALTH RIGHTS: PERSPECTIVES FROM HEALTHCARE STAKEHOLDERS IN NORTH INDIA

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Abstract

In health-care settings, stakeholder's knowledge, attitudes and perspectives influence their perception towards children, including children's rights and right to health. The knowledge and attitudes generally present a culture of how children's right are perceived and treated. This study explored the knowledge, attitudes and perspectives of 35 Indian health care stakeholders regarding children's rights and right to health and their perspectives on realization of the selected domains of rights in reality. The stakeholders acts as potential duty bearers in improving the children's rights status at a policy level. Findings revealed that most of the stakeholders were moderate (71.4%) to high level (85.7%) supporters of children's rights, including rights to health and education. Yet, majority of stakeholders did not have knowledge about specific domains of rights namely; right to protection (60.0%), practices related to rights (74.2%), right to health contains entitlements (68.5%) and non-discrimination (82.8%). Most of them suggested awareness strategies like defining 'right to health', inter and intra-department information cross-sharing, linking community level issues and narrowing the gap between policy and implementation. Overall, findings suggest a need to heighten awareness of children's rights especially right to health, which can improve the realization at local, district and state level.

Keywords: Child rights, health, knowledge, attitude, stakeholders, perspectives

Introduction

In recent years children's rights has received substantial social and political commitment[1]. India has adopted one of the most progressive United Nations Child Rights Convention (UNCRC) on child health rights oriented constitutions in the world and created

additional mechanisms to support implementation[2]. Despite early ratification on the right to heath, UNICEF reported highest under-five mortality in eight states namely Bihar, Jharkhand, Orissa, Madhya Pradesh, Chattisgarh, Rajasthan Uttar Pradesh, Uttranchal and Assam in India[3]. In 2008, 8.8 million children died before their fifth birthday[4]. Infant mortality rates, although have declined recently, are still alarmingly high worldwide, at 9.7% and 5% respectively[5]. As per the Special Rapporteur on the right to health 2010 report, India had a legally binding international human rights obligation to devote its maximum available resources to the health of its population however, it was recorded the lowest in the world[6]. Promoters of health and healthcare can facilitate or act as barriers to acheiving health rights[7]. Children need special voices of caregivers to attain right to health. It is important to undertstand the perceptions of various stakeholders in public health research to maximize the benefits of research[8]. There is lack of information regarding involvement of health care professionals in the context of children's rights in India. With this brief background on the problem of realization of right to health in India especially in case of children, the researcher aimed to study healthcare stakeholders.

The specific objectives of the study included;

1. To assess healthcare stakeholder's knowledge on children's rights (with specific focus on health rights) in India.
2. To assess healthcare stakeholder's attitude on children's rights (with specific focus on health rights) in India.
3. To document stakeholder's perceptions regarding the problem of realization of children's rights in India.

Materials and methods

The data used in this research paper are from the Future Health System (FHS)- Research Program Consortium young researchers grant study. As a part of the main study, the stakeholder analysis was conducted through a cross-sectional survey in January 2014 in Rajasthan. The participants came from four levels i.e village, block, district and state. The study was carried out in the following steps 1) Identification of key stakeholders, 2) Assessing their knowledge and attitude in relation to the children's rights (with specific focus on health rights), and 3) documentation of their perspectives regarding the problem of realization of children's rights in India.

Step I: Identification of key stakeholders

Identification of key stakeholders involved discussion with regional health work force and research team members. Purposive

sampling was utilized to finalize the stakeholders. Additionally, review of literature was also carried out to finalise the potential stakeholders and their categories. A list of categories is as depicted in Table no.1.
Table 1. Stakeholders identified and interviewed

A study semi-structured questionnaire included questions to capture demographic details and their work experience in years of the respondents.

Step II: Knowledge on children's rights and focus on health rights in India

To assess the knowledge on children's rights and right to health, the respondents were requested to rank on the four point Likert scale (1= Nothing at all; 2= Have only heard; 3= Know little about it; and 4= Very familiar with it) on the pre-determined UNCRC domains of children's rights. The related children's rights domains included; (1) understanding of children's rights, (2) practices relating to rights, (3) Right to health: promoting healthy lives (addressing survival, nutrition, health care services), (4) Right to education: providing quality education and (5) Right to protection: protection against abuse, exploitation and violence (combating child labor, child trafficking and child sexual abuse)[9]. The domain on children's right to health came from Office of the United Nations High Commissioner for Human Rights which involved key aspects of the right to health; (1) the right to health is an inclusive right (safe drinking water and adequate sanitation, safe food, adequate nutrition and housing, healthy working and environmental conditions, health related education and information and gender equality); (2) the right to health contains freedoms (right to be free from medical treatment / experiments and to be free from torture and other inhuman or degrading treatment), (3) the right to health contains entitlements (equality of opportunity for everyone to enjoy the highest attainable level of health, the right to prevention, treatment and control of diseases, access to medicines, maternal, child and reproductive health, equal and timely access to health services); (4) health services, goods and facilities must be provided with out any discrimination (non-discrimination: it is crucial to the enjoyment of the right to the highest attainable standard of health) and; (5) all services, goods and facilities must be available, accessible and acceptable and of good quality (functioning public health and health care facilities, goods and services must be available in sufficient quantity, must be accessible physically, financially and on the basis of non-discrimination, right to seek, receive and impart health-related information in an accessible format including persons with disability,

the goods, services and facilities must be medically and culturally acceptable and must be scientifically, medically appropriate and of good quality which includes trained health professionals, scientifically approved and unexpired drugs, adequate sanitation and safe drinking water)[10].

Step III: Attitude on children's rights (with specific focus on health rights) in India

Secondly, to assess the attitude of the stakeholders the responses were recorded as high-level, mid-level and low-level supporters of children's rights and child rights to health on three point Likert scale.

The validity of the content of the questionnaire was discussed with experts. The reliability of the questionnaire was established and the reliability score was 0.79.

Step IV: Perception-mapping of the key stakeholders

The selected key stakeholders were interviewed with help of in-depth interview guide. Questions and discussions focused on problems related to the realization of children's rights. The data was further analysed using inductive analysis where the researcher focused on the themes that emerged out of the data collection[11]. Similar words and phrases were grouped together into the themes. All data were transcribed verbatim, typed and archived. The transcribed data were categorized into themes and analysed manually. The themes emerged were; awareness of children's rights, capacity and challenges in supporting children's rights and promotion of children's rights in India.

Ethical consideration

Participation was voluntary. Verbal and written informed consent was sought from each participant before the administration of the tools. The interviewer explained the participants, research background, the objectives and details of the study. Names of the participants were coded into unique numbers to maintain their privacy and confidentiality. The study proposal was reviewed and approved by the ethical review committee of the Institute of Management Research University (IIHMR).

Results:

Table no.2 shows the demographic details of the stakeholders. More than half (57.1%) of the respondents belong to the age group of 36-45 years. Most of the respondents studied till graduate level

(74.2%). Maximum number of them were working for more than five years (77.1%) and were males (82.8%).

Table 2. Demographic profile of stakeholders,(N=35)

In the knowledge section (Table no.3), a majority, 20 (57.3%), 16 (45.6%) and 14 (40.1%), were 'very familiar' with right to education followed by right to health and general concepts of children's rights. In case of practices related to rights and right to protection, majority 26(74.2%) and 21(60.0%) answered 'nothing at all'. As far as, knowledge pertaining to children's right to health was concerned; majority 29 (54.2%) were 'very familiar' with only one concept of all services, goods and facilities must be available, accessible and acceptable and of good quality. The findings were stark on two main components of child right to health; majority 29(82.8%) and 24(68.5%) responded 'nothing at all' for concepts of non-dicrimination and entitlement. While, 13(37.1%) only heard about concept of the right to health contains freedoms. Table no.4 shows, majority 25 (71.4%) were mid level supporters of children's rights and 30(85.7%) were high level supporters of child right to health despite their low level of knowledge in the areas of children's rights. Additionally, Table no.5 shows correlation between different domains of children's rights and child right to health. A weak positive correlation was observed between knowledge and attitude in the particular domain of child rights.

Table 3. Frequency and percentage distribution of responses to knowledge based questions, (N=35)

Table 4. Frequency and percentage distribution of responses to attitude based questions

Table 5. Correlation between stakeholder's knowledge and attitude

Perspectives (Interviews)

During the interviews, stakeholders were aware at a general level and revealed that they support the concept of children's rights and right to health strongly and would like to part of its implementation. Twenty of thirty five stakeholders participated in the in-depth interviews.

Awareness of child rights

Most of them lack specific understanding of concepts of children's rights and right to health. The awareness is also low on the practical implementation of the children's rights. State and district level officers suggested; development of brief training materials for the staff.

The training modules should enhance importance of accountability and strategies to enforce rights at regional levels (stakeholder: state level).

There is a need to define 'health is a right' for children which will have positive impact in the society (stakeholder: state level).

Capacity and challenges in supporting child rights

Another group of stakeholders at block and village level mentioned, how the capacity building exercise was important however; dependent on higher level officials. The capacity building platform should be action-oriented in realization of children's rights.

Our department had a workshop on right-based approach in health, it was helpful to gain new insights on right to health (stakeholder: District level).

The training should be regularly conducted and informative. Moreover, the community level issues should be linked and resolve our understanding issues (stakeholder: Village level).

It is difficult to understand written brochures and notice. We need more community meetings, workshops and interactive sessions to strengthen our knowledge on right-based approach (stakeholder: Village level).

The findings also confirmed the importance of participatory learning methods to change attitude and inculcate practices. Majority of them also asked; who is the governing body responsible for the realization of the rights.

Community leaders and NGOs act as potential players in realizing the right to health as they are in close knit with the community and care-takers of children (stakeholder: Block level).

Promotion of child rights

The duty-bearers (state, district, block and village level) play critical role in turning rights obligation as reality.

The data from diffrent organizations should be cross-shared thus contributing to the gap between formal right based entitlements and on-the –ground realities (stakeholder: State level).

Provisions of learning should highlight guidelines to handle right related violations and plans for cascading knowledge, skills and practices within inter and intra-departments (stakeholder: State level).

By informing and involving the right-based mandate-holders would be a good practice to access state-level guidelines and information (stakeholder: State level).

The gap between policy and implementation should be narrowed (stakeholder: State level).

Discussion

The present study, which assessed knowledge and attitude and also mapped stakeholder's perspectives in relation to children's rights and child right to health, revealed that majority were not aware of the inclusive concepts of children's rights and right to health. However; almost all the stakeholders moderately or highly supported the concept. This is the first study which attempted to map stakeholder's knowledge, attitude and perspectives in relation to rights in northern region of India. Majority of the studies have focused on quantitative national-level health surveys to draw inferences on human rights approach linked to maternal and child health[12,13]. The study focused on one of the EAG state: Rajasthan because there is a significant proportion of children and it ranks low on child health indicators despite having national-level child rights commission, child health policies and a special state level girl child policy established in 2012. Around 57.3% of the stakeholders were very familiar with the concept of right to education. A similar study evaluated attitude of parents towards child rights, it showed parents had favorable attitude towards right for education[14]. The in-depth interviews with the stakeholders evaluated different factors in determining the strategies which needs to be framed in relation to the realization of these rights. Some of the state and district level stakeholders shared realization of the children's rights or right to health is more than just entitlements, it is also having freedom to exercise these entitlements. They also shared, apart from training, cross-sharing and interactive sessions play critical role in understanding rights. These findings were similar to Stellmacher and Sommer study on promoting human rights skills which focused more than improving knowledge and attitude.[15] Lastly, it was believed at the state level the gap between policy and implementation should be narrowed down. A study by A sen, 2005 shared similar views on translating the intent of policy into freedoms that enable vulnerable populations to change their vulnerabilities to realizing their capabilities and is the key role for human rights to work at local, national and global levels[16].

Conclusion

Present study concludes a 'right-based' knowledge and approach is required to tackle the problems of children in India. A 'right-based' rather than 'welfare or need based' approach will place a legal

obligation upon stakeholders and bring in accountability. The responsibility of these child rights and right to health rests with the parents and the proximal care takers such as village, community leaders, local health care officials and the state. They must oversee the right-based program implementation and report the violations. Stakeholder analysis is an important starting point for the right-based approach in view of incorporating stakeholders' views. The study evidences generated add to the knowledge particularly for countries with similar settings where they are unaware on the right-based knowledge and attitude and that are planning to set up right-based approach especially for children.

Conflict of interest

The author declares no potential conflicts of interest with respect to the research, authorship, and/or publication of this article. The views expressed are solely that of the author and are not necessarily that of DFID.

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Table 1. Stakeholders identified

Level	Stakeholders	Number (N=35)
State	Ministry of Health	3
	Rights commission	3
District	District Hospital	3
	ICDS- DI	1
	ASHA in-charge	1
Block	CHC	3
	Private providers	3
	Public providers	3
Village	NGO representatives	5
	Community leaders	5
	Health care providers	5

Note: ICDS: Integrated Child Development Scheme, DI: District in-charge, ASHA: Accreditated Social Health Activist, CHC: Community Health Centre

Table 2. Demographic profile of stakeholders,(N=35)

Characteristics	Stakeholders (N%)
Age (Years)	
25-35	11(31.4)
36-45	20(57.1)
Above 45	4(11.4)
Gender	
Male	29(82.8)
Female	6(17.1)
Education	
Undergraduate	26(74.2)
Post-graduate and above	9(25.7)
Work experience (Years)	
1-5	2(5.7)
6-10	27(77.1)
10 and above	6(17.1)

Table 3. Frequency and percentage distribution of responses to knowledge based questions, (N=35)

Domain	Nothing at all	Have only heard	Know little about it	Very familiar
Child Rights				
General understanding	4(11.4%)	6(17.1%)	11(31.4%)	14(40.1%)
Practices related to rights	26(74.2%)	5(14.2%)	3(8.8%)	1(2.8%)
Right to health	3(8.6%)	2(5.7%)	14(40.1%)	16(45.6%)
Right to education	5(14.2%)	4(11.4%)	6(17.1%)	20(57.3%)
Right to protection	21(60.0%)	10(28.5%)	2(5.7%)	2(5.7%)
Child Right to Health				
the right to health is an inclusive right	-	-	26(74.2%)	9(25.7%)
the right to health contains freedoms	11(31.4%)	13(37.1%)	11(31.4%)	-
the right to health contains entitlements	24(68.5%)	9(25.7%)	1(2.8%)	1(2.8%)
health services, goods and facilities must be provided with out any discrimination	29(82.8%)	4(11.4%)	2(5.7%)	-
all services, goods and facilities must be available, accessible and acceptable and of good quality	1(2.8%)	5(14.2%)	10(28.8%)	19(54.2%)

Note: (-): No response recorded

Table 4. Frequency and percentage distribution of responses to attitude based questions

Attitude level	Child rights (N=35)	Child right to health (N=35)
Low level supporters	3(8.5%)	2(5.7%)
Mid level supporters	25(71.4%)	3(8.6%)
High level supporters	7(20.1%)	30(85.7)

Table 5. Correlation between stakeholder's knowledge and attitude

Variables	rho	*P-value*
Knowledge and attitude on child rights	0.172	<0.001***
Knowledge and attitude on child right to health	0.067	0.156

***Significant at $p < 0.000$